Meader Family Dentistry

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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions or concerns, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient's Name ______________________ Sex ______ Date of Birth ______________
SINGLE/MARRIED/WIDOWED/DIVORCED

Parent's Name (if patient is child) ______________________ Social Security # ______________

Address ____
STREET APT. # CITY STATE ZIP

Telephone: Home ______________ Business ______________ Ext. ______

Employer ______________ Title ______________ How Long? ______

Spouse's Name ______________ Spouse's Employer ______________

Title ______________ Telephone ______________ Ext. ______

Person to contact in case of emergency (other than spouse) ______________

Address ____

Telephone: Residence ______________ Business ______________ Ext. ______

Referred By ____

Party Responsible for Payment of Account ______________________

Dental Insurance ______________ Group # ______________ Subscriber's SSN ______________

Subscriber's Name ______________ Subscriber's ID# ______________ Subscriber's D.O.B. ______________

MEDICAL HISTORY

Your physician's name ______________________ Telephone ______________

Date of last visit ______________ Have you had any serious illness or operation? ☐ Yes ☐ No

If yes, please describe ____

Are you currently under physician care? ☐ Yes ☐ No If yes, describe ______________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______________

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please check (√) if you have had any of the following:

☐ AIDS/HIV Positive
☐ Anaphlaxis
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial heart valves
☐ Artificial joints
☐ Asthma
☐ Atopic (allergy prone)
☐ Back problems
☐ Blood disease
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Corlisone treatments
☐ Cough, persistent
☐ Cough up blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Food allergies
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems
Describe ______________
____
☐ HemophiliaAbnormal bleeding
☐ Herpes
☐ Hepatitis
☐ High blood pressure
☐ Jaw pain
☐ Kidney disease or malfunction
☐ Liver disease
☐ Material allergies
(latex, wool, metal, chemicals)
☐ Mitral valve prolapse
☐ Nervous problems
☐ Pacemaker/Heart surgery
☐ Psychiatric care
☐ Rapid weight loss or gain
☐ Radiation treatment
☐ Respiratory disease
☐ Rheumatic/Scarlet fever
☐ Shingles
☐ Shortness of breath
☐ Skin rash
☐ Spina Bifida
☐ Stroke
☐ Surgical implant
☐ Swelling of feet or ankles
☐ Thyroid disease or malfunction
☐ Tobacco habit
☐ Tonsilitis
☐ Tuberculosis
☐ Ulcer/Colitis
☐ Venereal disease

List medications you are currently taking, if any:

____
____

List drug allergies, if any:

____
____